PRACTICE OBSERVED

Practice Research

Attitudes of doctors to the Alma Ata recommendations in Sri Lanka

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Abstract

A detailed postal questionnaire was sent to 400 general practitioners, hospital doctors, and Ayurvedic practitioners in Sri Lanka as part of a wider study to investigate the delivery of primary medical care. The responses to questions that were related to the Alma Ata recommendations, which aim at providing "health for all by the year 2000," and the perceived health needs of the population are reported. Basic sanitation, clean water, adequate nutrition, and improved health education were considered to be the most important needs. When asked to suggest one change in health care 30% of the doctors recommended the integration of primary and secondary care services.

Introduction

The importance of primary health care as opposed to secondary health care has been recognised for more than a decade and was summed up in the high sounding rhetoric of the Alma Ata declaration of 1978.[1] Governments have been encouraged to ensure that "essential care will be accessible to all individuals and families in an acceptable and affordable way and with their full participation". H Mahler, Address to 11th International Federation of Pharmaceutical Manufacturers Associations, Washington DC, 1982.[2] There is little evidence so far of widespread change as a result of ambitious plans.[3] To implement the aims of the Alma Ata declaration of health for all by the year 2000, the energy and enthusiasm of existing providers of care have to be harnessed and more resources provided.[4]

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The government of Sri Lanka aims at providing an island wide preventive and curative service at both primary and secondary care levels. Yet in terms of resources and personnel this is hospital biased and curative dominated. In addition, there is a largely private primary care sector providing Western and traditional medicine which, it is estimated, is used by half of the population. I studied the organisation of primary care in Sri Lanka and this paper reports on the attitudes of doctors to the Alma Ata recommendations.

Method

A detailed postal questionnaire was sent to 342 members of the two professional bodies that represent general practitioners, the Sri Lankan College of General Practitioners and the Independent Medical Practitioners Association. In addition, questionnaires were sent to the 27 hospital doctors, 27 traditional medicine Ayurvedic practitioners, and 16 general practitioners not members of either professional body, who were working in the town of Negombo (population 60 000). There were 34 sets of questions concerning personal and practice characteristics.

Results

A total of 229 completed questionnaires were returned, a response rate of 74% of the total population of general practitioners after allowing for those who had died, retired, or moved (table I). From a summary of the 22 Alma

TABLE I—*Response to questionnaire*

	No (%) responding
General practitioners:	
College: n=169	138 (81·7)
Practitioners' association: n=113	71 (62·8)
Other: n=16	9 (56·3)
Ayurvedic practitioners: n=27	18 (66·7)
Hospital doctors: Negombo: n=27	6 (22·2)

Ata recommendations doctors were asked to select five in order of importance. Those considered most important by 174 respondents were content of primary care 84·48·3%, the needs of the community 21·12·1%, international need for cooperation 19·10·9%, and increased national commitment to primary care 18·10·3%. No other recommendation was mentioned by more than seven respondents.

The fifth Alma Ata recommendation, which concerns the content of primary care, was subdivided into 12 sections and respondents asked to list these in order of importance. Of the 191 respondents, 138 considered the four most important aspects to be basic sanitation, adequate safe water, health education, and proper nutrition. All respondents were then combined, and the rank order is given in table II.

Health care needs—In an open question doctors were asked to state the four most important health care needs of the population. Twenty different ones were mentioned by 234 respondents. Clean water, basic sanitation, adequate nutrition, and health education were equally favoured as the first choice and between them made up 72·5% of needs considered most important. Table III shows the 10 most commonly mentioned needs in the combined responses to this question. There was no difference in response between the groups of health care providers. Respondents were also asked: if you could make one change in the health care system of Sri Lanka what would it be? Table IV gives the most commonly mentioned of the 234 responses made by 189 doctors. No significant differences between types of practitioners were found.

Comparison of responses to different questions—Analysis was undertaken to answer the question: Do those who consider health education the most important aspect of primary care also place this first in the health care needs section? Seventy per cent of those who considered health education to be the most important Alma Ata recommendation also put it as the first health care need. The same percentage was found between the responses concerning clean water, basic sanitation, and adequate nutrition. Using the Kendal coefficient of concordance the personal and practice characteristics of the respondents were compared with their attitudes to the Alma Ata recommendations and to the needs of the population. No differences were found

TABLE II—*Order of importance of Alma Ata recommendations on content of primary care: n=191*

Category	Overall rank importance
Basic sanitation	1
Adequate safe water	2
Health education	3
Proper nutrition	4
Identifying, preventing, and controlling health problems	5
Family planning	6
Maternal and child care	7
Immunisation	8
Prevention of endemic disease	9
Provision of essential drugs	10
Appropriate treatment of common disease	11
Promotion of mental health	12

TABLE III—*Health care needs: combined response n=234*

Need	Frequency of mention
Health education	115
Clean water	111
Adequate nutrition	109
Basic sanitation	101
Appropriate cheap available drugs	49
Immunisation	48
Family planning	45
Aspects of maternal and child health	37
More rural facilities	31
Endemic disease control	31

TABLE IV—*Recommended changes in health care: n=189*

Rank order	No (%) responding
1 An integrated national health service	62 (32·2)
2 Increased emphasis on prevention	22 (9·4)
3 Effective referral system, primary to secondary care	16 (8·5)
4 Improved training of staff	16 (8·5)
5 Eliminate quackery	15 (8·4)
6 Facilities better spread	14 (8·0)
7 More health education	13 (5·6)
8 General economic improvement	13 (5·6)

Study of "discharge communications" from hospital

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Abstract

All hospital discharge communications concerned with acute admissions from one general practice over a three month period were analysed. There was an appreciable delay between the time that the patient was discharged and the information was received by the general practitioner. Just over half of the patients had contacted their general practitioner after discharge before the general practitioner had received any information. The content of the communications was variable, and important subjects were frequently omitted. No communication was received for 11% of the discharged patients.

There is a need for more efficient communication between secondary and primary care.

Introduction

There is general agreement that when admission to hospital is necessary the interests of patient, community, and health service are best served by prompt admission and early disharge. To achieve this safely, however, close cooperation between hospital and community staff is essential, and the key factor is effective and reliable communication. There are, however, no published results of audits of the effectiveness of communications, which shows a major gap in our knowledge.

This pilot study was therefore set up to test the hypothesis that the letters from hospital medical staff about patients returning home after discharge from hospital are adequate.

Method

The practice population that provided a data base for the study is in Runcorn, Cheshire, a new town development with a population of roughly 100 000. Most of the 9870 patients who are registered with this practice have come from the inner city districts of Liverpool. There are five general practitioner principals in a new health centre, one of whom works part time and has no on call duties, and two trainee general practitioners. A commercial deputising service is used for night calls and some weekend cover.

A prospective study of all hospital discharge communications concerning the acute admissions of patients from the practice was carried out over a three month period. An acute admission was defined as one that was arranged immediately after assessment by a member of the practice, whether a principal or an assistant, with a minimum stay of 24 hours in hospital. The following were excluded: maternity admissions, admissions resulting from domiciliary visits by consultants, and admissions by a doctor who was not a member of the practice, including temporary "call service" doctors.

The practice has a special register of acute hospital admissions, which allowed the relevant data from all the practice doctors to be analysed. At the time of admission clinical and personal details of each patient who was entered in the study were recorded on a separate data sheet for analysis.

A discharge communication was defined as any written communication received from the admitting hospital, whether it was a personal letter, a typed form, or another format. When a communication arrived at the practice it was assessed and the findings entered on a record sheet. Both first communications and, where appropriate, second communications were assessed by the same doctor using a standardised technique, and the activities of all the hospitals that served the patients in the practice were included.

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In all cases an assessment was made to show the following.

Time—(*a*) Date of patient's discharge. (*b*) Date that the discharge letter was prepared. (*c*) Date the general practitioner received the discharge letter. (*d*) Date of first contact of the patient with the practitioner after discharge from inpatient care—defined as a contact which resulted in an entry in the notes, such as a visit, consultation, or telephone discussion.

Content—The communications were scrutinised for a statement of: (*a*) Adequate patient details, which were defined as name, address, and date of birth. (*b*) Investigations performed, which were defined as a statement of any procedures with associated positive or negative findings or a statement that no investigations had been performed. (*c*) Diagnosis. (*d*) Treatment given in hospital. (*e*) General practitioner follow up for counselling or other further treatment. This was defined as a statement of continuing care other than medication at the time of discharge. (*f*) Information given to the patient or relatives concerning the illness. (*g*) Review date, defined as a statement of intention as to whether a review was planned or not. (*h*) Further information to follow—defined as a statement that further information was to follow or not. (*i*) A legible signature of the doctor sending the communication. (*j*) The name of the consultant in charge.

Results

In the three month period of the study there were 89 acute hospital admissions from the practice. No communication was received for 10 (11%) of the admissions by the end of two calendar months after discharge. Thus 79 admissions resulted in at least one discharge communication, which was the only communication for 33 (37%) admissions, and a second discharge communication was received for 46 (52%) of the admissions.

Time

For "first communication," which was generally a hand written proforma note, the median time interval from discharge to receipt by the general practitioner was eight days. The distribution of the delay is significantly skewed (table I). Forty two (53%) of the 79 patients contacted their general practitioner before the first discharge communication had been received.

TABLE I—*First and second communications: delay from initiation to arrival with general practitioner*

Delay (days)	Frequency: First communication n=79	Frequency: Second communication n=46
0–9	47	1
10–19	20	16
20–29	4	12
30–39	6	12
40–49	1	3
50–59	1	2
Median	8	24

For "second communication," the median delay from the time of discharge to the time of receiving the discharge letter was 24 days. Of the 46 patients for whom a second communication was received, 37 (80%) had contacted their general practitioner before this had arrived.

Content

Table II gives an analysis of the content of first and second communications, the first communications being divided into those that preceded a second and those that were the only communication. A comparison of these two divisions shows a significant difference only in the statement of investigations performed.

Though details about the patient were accurate in nearly all cases, the content of the communications was variable and important subjects often omitted (table II). For example, the investigations were included in only a quarter of the 79 initial communications and in just over three quarters of the second communications. Details of hospital admission such as the diagnosis and treatment were not always stated. Suggestions to general practitioners for management were rarely included, nor was the general practitioner usually informed about what the patient had been told. Future care or review of the patient by the hospital was not clearly indicated, and only a quarter of the first communications said whether or not correspondence would follow.

TABLE II—*Content of first and second communications*

Content	First communication: First and only (33 admissions) No (%)	First communication: First and preceded second communication (46 admissions) No (%)	First communication: All first (79 admissions) No (%)	Second communication (46 admissions) No (%)
Patient's details	32 (97)	46 (100)	78 (99)	46 (100)
Investigations	14 (42)	6 (13)	20 (25)	36 (78)
Diagnosis	24 (73)	35 (76)	59 (75)	40 (87)
Treatment	28 (85)	29 (63)	57 (72)	44 (96)
General practitioner follow up prescription	0	3 (13)	6 (8)	1 (2)
Information to patient	2 (6)	0	2 (3)	4 (9)
Review date	22 (67)	28 (61)	50 (63)	38 (83)
Further correspondence	10 (30)	15 (33)	25 (32)	
Legible signature	15 (45)	16 (35)	31 (39)	39 (85)
Consultant in charge	25 (76)	39 (85)	64 (81)	46 (100)

Not all communications had a legible signature. The name of the consultant in charge was stated in most first communications and in all second communications, however.

Overall, the second communication contained more details than the first, apart from information to the general practitioner concerning management in the community, but was received for only 46 (52%) of the 79 admissions and after an appreciable delay.

During the study 123 visits were made by a deputising service, which resulted in five hospital admissions. In addition, 28 patients were admitted either from 999 calls or direct from casualty or outpatient departments.

Discussion

Hospital care temporarily removes a patient from the continuing care of the general practitioner and the primary care team, and the findings of this study indicate that there is a need for improvement in the communication between the hospital and the general practitioner. Firstly, when a patient is returned to the care of the general practitioner the hospital findings should be communicated rapidly, otherwise the home management of the patient will be based on uncertainty. In this study general practitioners were contacted by over half of the patients before the general practitioner had received any information from the hospital. The medicolegal implications of failure to communicate cannot be overemphasised.

Secondly, communication must be adequate. The findings of this study raise the question: Is the role of the general practitioner in the continuing care of patients always understood and appreciated by hospital staff? The details of admission—the investigations, diagnosis, and treatment—should be conveyed in all cases. The general practitioner and the primary care team need to know what type of care the patient requires. The patient should not become the "forgotten party," and the doctor should know what information was given to the patient in hospital. The future role of the hospital also needs to be made clear, especially whether there is to be follow up or not, and since the general practitioner will need further information at least the name of the consultant in charge should be stated.

In an attempt to improve discharge communications the present system may be revised by general practitioners and their hospital colleagues. A discharge letter with an agreed content is necessary, and a limited time delay agreed. The delay might be defined from this study as the period when a minority of patients have contacted their general practitioners after discharge from hospital. Feedback is essential to assess and improve communications, and regular discussion with hospital colleagues may provide this. In addition, the patient could hold the discharge letter. This not only might help to improve communication between primary and secondary care, but it might help to shift the responsibility for health from the doctor to the patient. The form and content can be decided on, drawing on the experience from other patient held record cards.[1] The use of a computer may also be helpful.

A discharge communication from the hospital to the general practitioner must meet the criteria demanded by the needs of continuing patient care. These are known to the general practitioner from experience and need to be assessed further. There is much debate over the time spent in hospital by trainees for general practice. This study implies that some experience in general practice by doctors who are pursuing hospital careers is needed.[2] An appreciation of the needs of general practice might make the content of discharge communications more appropriate, lessen the delay in sending them, and promote safer management in the community with less risk of medicolegal misadventure.

References

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100 YEARS AGO

At the first of his course of three lectures on the Historic Arts of Japan, on Monday last, at the Society of Arts, Mr. Ernest Hart showed some swords of physicians of the ancient *regime* of Japan. The sword was *de rigueur* for gentlemen in Japan, and the necessary sign of professional position, however unwarlike. The physicians, however, commonly carried a bladeless sword. Of these, Mr. Hart showed some exquisitely decorated specimens. One of these was of the seventeenth century. It was of iron-wood, delicately inlaid with floral scrolls in silver and gold, a work of great artistic difficulty and perfection. It is profusely decorated with the "kiri-mon and pho," crests of the mulberry leaf and the Japanese phoenix, which was the crest of the Empress. It was evidently a sword carried by the physician to the wife of the Mikado. The appliques, or "menouki," are chased in gold by Goto Fujuo, a celebrated metal-worker of the 17th century. Another wooden sword was carved in the form of a fish, and on the hilt was mounted a reproduction of an ancient gold coin of the Chinese dynasty of Hang (800 B.C.). At the next lecture, on Tuesday, May 11th, at 8 P.M., the specimens of ancient lac will be discussed; they include a series of upwards of 300 inros, or small medicine-boxes in compartments, which Japanese gentlemen have, for many hundreds of years, carried suspended at their girdles, and on which the great *lacqueurs* of Japan have expended all their artistic skill, and which are frequently specimens of the most exquisitely delicate and refined work in gold and coloured lacs of every variety. The study of inros is, in itself, a historic study. (*British Medical Journal* 1886;i:898.)